PEDIATRICS FOR PARENTS™
The Newsletter for People Who Care for Children

A Letter from the Editor

In the last issue I told you about the changes that will be occurring in the newsletter. The most significant one is the creation of a free monthly email newsletter. It will contain a brief description of all the articles in that month's issue with links to each article on the *Pediatrics for Parents* website.

The second change is that I will continue to produce the 16-page PDF version of the newsletter, but it will now cost $5 per year. So for less than the price of two lattés at your local coffee shop, you will be able to continue to receive 16 ad-free PDF issues a year of *Pediatrics for Parents*. I think it's well worth the small cost and hope you do, too. You can send a check to the address below or pay via PayPal.

I also want to remind you of a readers survey. The survey will help me continue to offer the best publication I can by knowing more about the readership, what features of the newsletter benefit you most, and how the newsletter can improve. If you haven't already completed the survey then click HERE. Your participation is invaluable.

Some things will stay the same. I will still publish the print version of the newsletter. Our medical writers and columnists will continue to write informative and educational articles on myriad pediatric issues. We will still offer free podcasts on our website. And we will continue to strive to be the best no-frills parenting publication out there. Thank you for your continued support.

- Rich Sagall, MD

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Pediatrics for Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Unfilled Cavities

Children from low-income families are five times as likely to have untreated dental caries (cavities) than kids from high-income families. The Agency for Healthcare Research and Quality found that 31% of low-income children aged two to five years have untreated dental caries. The percentage rose to 37% for children aged six to eleven and fell to 27% for kids aged 12 to 17.

Children from wealthier families reported much lower untreated cavity rates: 6% for kids two to five years old, 12% for children six to eleven years old, and 7% for children 12 to 17 years old.

The American Academy of Pediatric Dentistry recommends twice-yearly dental check-ups for all children. Seventy percent of children from wealthy families had the recommended number of check-ups while only 36% of children from poorer families did.

Untreated dental cavities cause many problems including pain, tooth loss, and more serious infections. Some children need more frequent visits to the dentist due to increased risk of decay, unusual dental growth patterns, or poor oral hygiene.

Agency for Healthcare Research and Quality, News and Numbers, 4/2/08

Infant Mortality Gap

Despite all the advances in neonatology, the rate of black infant mortality is much higher than the rate for white infants. The infant mortality rate for white infants from 1995 to 2000 was 4.9 deaths per 1,000 infants compared to 11.4 per 1,000 births for black infants. During the six years, there were an estimated 3,303 “excess” infant deaths among blacks.

One reason for the disparity is the percentage of very low birthweight infants. For white babies, the rate increased from 0.4% to 0.6% of all births. This compares to an increase from 1.4% to 1.9% for black infants.

According to lead researcher Martha Slay Wingate, DrPH, of the University of Alabama-Birmingham, “Prenatal care, while not a panacea for preterm birth, may play a role in addressing these access-to-care issues.”

Journal of Obstetrics & Gynecology, 01/08

Ticks and Kids...Not a Friendly Mix

By Oreta Marie Samples, MPH, VT

The summer months bring to children promises of longer days, no school and endless opportunities for fun outdoor activities. Unfortunately, the increased outdoor activities during the warmest months of the year give parents yet another concern as to the well being of their children. In addition to guarding against sun exposure, and poison ivy, children who spend time outdoors may be at risk for bites and subsequent disease caused by ticks. Such diseases are called Tick-borne Rickettsial Diseases (TBRD) and include such diseases as Rocky Mountain Spotted Fever (RMSF) and Lymes Disease.

Ticks are members of the insect world and share the same taxonomic classification as spiders and scorpions (i.e. Arachnida); they are divided into three families. Of these families two are deemed to be harmful to humans and animals. The first, Argasidae, is commonly known as "soft ticks" while the second family, Ixodidae, represents the "hard ticks."

A well-known disease, Rocky Mountain Spotted Fever is caused by a bacteria that is carried by the tick Dermacentor andersoni (found in the Western US) and Dermacentor variabilis (found in East, Central, and Pacific parts of the U.S.). They are commonly referred to as the Rocky Mountain Spotted Fever and American Dog Tick, respectively. This disease is characterized by early onset of symptoms commonly associated with the flu, such as nausea, vomiting, head and muscle aches, and lack of appetite (due to nausea). As the disease progresses, a rash may appear, which is comprised of non-itchy pink spots that appear raised and generally are noticed around six days after the tick bite occurs. Children may also complain of abdominal pain or joint pain.

Diagnosis is often difficult during onset due to non-specific common complaints and alternative diagnoses. Diagnosis is confirmed by three observations: fever, rash and tick presence/bite. However, parents and pediatricians should not wait for confirmation by lab results to begin treatment as this disease is aggressive and may prove fatal, especially in the young and immuno-suppressed. Rather, symptomatic treatment should be started immediately. It is generally accepted that the drug therapy of choice for this disease is Doxycycline given over the course of five to ten days. Prognosis is generally excellent if diagnosis and treatment are started early.

Lymes Disease is another tick-borne disease that is transmitted by the tick Ixodes dammini. Although signs may include flu-like symptoms similar to RMSF (fever, head and muscle aches, fatigue), there is a major difference in the appearance of a rash, which resembles a raised bull's eye and may be seen between three and thirty days after the initial tick bite, increasing in size over time. If left untreated, this disease can cause bouts of arthritis as well as chronic neurological problems.

Diagnosis is made on the basis of the bull's eye rash and the presence (finding) of tick. Confirmation may be made either by ELISA or Western Blot testing of blood serum. As with RMSF, due to the serious nature of Lymes Disease, it is advisable to begin supportive treatment and drug therapy while awaiting test results.

Treatment for children who are suspected of having contracted Lymes Disease is by antibiotic therapy using Doxycycline, Amoxicillin, or Cefuroxime axetil. According to CDC sources, those who begin treatment early generally recover quickly, while patients who are diagnosed in late stages of the disease may require two courses of therapy at four weeks each. As with Rocky Mountain Spotted Fever, early diagnosis and intervention lead to a faster recovery time.

So, what can parents do to protect children from tick-borne diseases such as RMSF and Lymes Disease? Initially, take stock of the surroundings children live in. In outdoor areas, keep grass mowed in yards and restrict areas of access to children that may harbor ticks such as forest and woodland areas. Before allowing children to go outside, apply child-friendly insecticides that will discourage biting insects such as mosquitoes and ticks. But keep in mind that children are not miniature adults and commercial insecticides can be harmful to children if using a product not specifically designed for them due to inappropriate concentrations. To avoid such toxic effects, use only child-approved products in accordance with manufacturer's instructions.

If your family includes man's best friend or a friendly feline, use topical flea and tick preventatives such as Advantage or Frontline products to ensure that Fido or Fluffy doesn't bring home unwanted guests. In addition to treating your animal, maintain sanitary conditions in your pet's living area such as bedding and toys that may harbor ticks or fleas.

If after all of these precautions you discover a tick attached to your child, don't panic. Using tweezers, grasp the tick as close to the child's body as possible and pull the tick straight out, checking to make sure you remove the whole insect. Then clean and disinfect the area as you would any minor wound. For future reference, preserve the tick in a discarded medicine bottle in rubbing alcohol in case of the need for later identification. Carefully monitor your child for any future symptoms indicating the need for further medical care. If child displays symptoms or you feel uneasy, never hesitate to seek the help of your pediatrician. After all, ticks and kids are not a friendly mix.

Oreta has recently received her masters in public health and is now pursuing a PhD in health sciences. In addition to freelance writing, she is a full-time veterinary technician at Fort Valley State University in Ft. Valley, Ga. Her work has appeared in Veterinary Technician Journal *and* I Love Cats.

Nexium for Kids

The Food and Drug Administration (FDA) recently approved the use of Nexium (generic name esomeprazole magnesium) for the short-term treatment of gastroesophageal reflux disease (GERD) in children one to eleven years old. Nexium is a proton pump inhibitor (PPI) that decreases the amount of acid secreted by the stomach. Nexium has been approved for use in children as a delayed-release capsule and a liquid form.

Even before the FDA approval, doctors have been prescribing Nexium to children under 11 years old because it's an effective drug and works well for some children suffering from GERD. The FDA approval supports what these doctors have known and have been practicing. The approval was based on both extrapolation of studies done in adults and new studies done in children.

The most common side effects of children taking Nexium are headache, diarrhea, abdominal pain, nausea, gas, constipation, dry mouth, and sleepiness.

FDA, 3/08

Solid Food and Allergies

Doctors usually tell parents of a newborn not to introduce solid foods until the baby is at least four to six months old, ostensibly to lessen the chances that the infant will develop atopic diseases – asthma, allergic rhinitis (runny nose), eczema, and food and inhalant sensitization – later on in life.

In a recent study that was published in the January 2008 issue of *Pediatrics*, researchers in Germany looked into whether delaying the introduction of solids past four or six months of age acts as a protective measure against children developing an atopic disease at age six. For the study, the researchers analyzed data from an ongoing birth cohort study (Influences of Lifestyle-Related Factors on the Immune System and the Development – LISA for short). Specifically, parents of 3,097 children who were born in four cities in four hospitals in Germany in November 1997 though January 1999 filled out six questionnaires over a six-year period (at child age 0.5, 1, 1.5, 2, 4 and 6) about their child's symptoms of eczema, asthma, allergic rhinitis and other medical conditions, as well as diagnoses. At the six-year follow-up investigation, researchers had complete data on solid foods and atopic outcomes on 2,073 of the original 3097 children.

Contrary to popular belief, the results indicated that there was "no evidence for a protective effect of a delayed introduction of solids (past four or six months) on asthma, allergic rhinitis, or food or inhalant sensitization against food or inhalant allergens at 6 years of age." In fact, lead researcher Anne Zutavern, MD and her colleagues concluded that avoiding solid foods and a less diverse diet in the first four to six months is positively associated with a food sensitization. (The study was inconclusive about the relationship between solid food introduction and eczema.)

Pediatrics, 1/08

Lack of Sleep and Injuries

If your preschooler doesn't get enough sleep, then he has twice the chances of being injured as preschoolers who get enough sleep. Every year 20-25% of all children in this country sustain an injury serious enough to require medical attention. The National Sleep Foundation recommends children three to six years old get 11 hours or more sleep every day.

Christina Koulouglioti, PhD, RN, the lead researcher of a study that looked at the relationship between sleep adequacy and injuries sustained by children ages 18 months to four years old, says, "The results of our study have significant implications for the prevention of injuries. The findings provide additional support for the essential role of poor sleep as a risk factor for injuries among preschool children."

Public Health Nursing, 3-4/08

"It's wonderful that other parents can now have the benefit of Peggy's advice and support by reading this charming book!"
—Julie Strong, Lexington, Massachusetts

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How to Keep Your Child Safe

By Vikki Sloviter

Summer is here, which means the weather is warmer and children are spending more time outside. We've all heard adults lament how times have changed since they were young, when they could walk through town to their friend's house, or take public transportation to school, without their parents batting an eye; they always returned home without incident.

According to the National Center for Missing & Exploited Children, approximately 2,185 children a day are reported missing. Most of these children return home safely. In 1999, more than 750,000 children were reported missing for one reason or another. And, media reports of high profile child abductions do nothing to quell parents' already uneasy concerns about their children's safety. Most of those publicized abductions are "stereotypical abductions," where the perpetrator didn't know the child, took him more than 50 miles from home, and kept him overnight with the intent to permanently keep or kill him. But those types of abductions are exceedingly rare. In fact, of the more than 58,000 nonfamily abductions in 1999, only 115 were stereotypical abductions. More common are "family abductions," where a non-custodial parent or other family member takes a child. In fact, in 1999 there were more than 200,000 children who were victims of family abductions. In 57% of those cases, the child was missing from his caretaker.

Knowing that more children are abducted by people they know (parents, relatives, acquaintances) than by strangers, parents don't need to instill the "never talk to strangers" mantra in their children as much as they should educate their children about general safety measures. Here are some personal safety concepts to teach your children so they can become happy and safety-aware adults:

- Teach your child his first and last name, home address, phone number and your name.
- Make sure your child knows how to dial your cell phone or work phone number, and 9-1-1.
- Make sure you have a trusted friend or family member whom your child can call in an emergency.
- Teach your child to keep your exterior doors locked and never to talk to – let in – someone unknown to him or unexpected when you're not home.
- Choose babysitters carefully. Ask for and call references, drop-in unexpectedly on the sitter while s/he is with your child, and ask your child how the sitter was.
- Do not write your child's first or full name on clothing, backpacks, lunchboxes, or bike license plates. A stranger could see your child's name and call out to him, making your child think he knows that person when he doesn't.
- Never let your child walk or bike to school alone. She should have a buddy.
- If your child walks to school, walk the route with her and point out houses or places to go if she feels unsafe.
- Walk around your neighborhood with your child. Point out whose houses she can visit and all the ways she can get back home.
- Tell your child to always come get you (or a trusted neighbor) if there's a dangerous situation or questionable person.
- Teach your child that she must always ask your permission before leaving the house, even if she's just going next door. You always need to know if your child isn't in the house.
- Teach your child never to approach a strange vehicle or person, unless a trusted adult is there.
- Since many children are abducted by someone known to them, the concept of "stranger danger" is misleading and potentially dangerous. If your child is ever in trouble, she may need to approach a "stranger" to ask for help. Instead, teach your child about suspicious or questionable situations, not "strangers."
- Ask you child "what if?" questions about safety and see how he responds ("What would you do if someone asked you to help him find his lost dog?").
- When on family outings or in public places, arrange an easy-to-reach meeting spot with your child in case he gets separated or lost.
- Teach your child what kinds of people she can approach for help if in a public venue (shopping mall, amusement park): police officers, security guards, store clerks with nametags.

For more information on child safety in the home, on the Internet and outside the home, visit www.take25.org or www.missingkids.com.

Vikki Sloviter received her BA in History of Science and Medicine from Yale University. She lives in Bucks County, Pennsylvania with her husband and three young children. She also proofreads, copy edits, researches and writes for Pediatrics for Parents *and NeedyMeds.com.*

Assessing the Home Environment for Your Child's Motor Skill Development

By Carl Gabbard, PhD

Contemporary research in child development suggests quite convincingly that an optimal level of development occurs with a stimulating environment, especially during the first two to three years of life. In essence, rich environments produce rich minds and bodies. Of the various factors comprising the environment, few would disagree that your home is a primary agent for learning and development. For the past half century, considerable effort has been devoted to better understanding the relation between the home environment and selected aspects of the child's development. Interestingly, one of the most striking and consistent findings has been availability of stimulating play materials as a predictor of future mental behavior.

In an effort to better understand home characteristics and affordances (opportunities) that might promote motor skill development in young children, researchers from Texas A&M Department of Health & Kinesiology (myself and Priscilla Caçola) and Motor Development Laboratories of the Instituto Politécnico Viana do Castelo, Portugal (Louis Paolo Rodrigues) created the Affordances in the Home Environment for Motor Development Self-Report (AHEMD-SR). The inventory has proven to be a valid and reliable instrument for assessing how well home environments afford movement and potentially promote motor development in children 18- to 42 months of age.

The AHEMD-SR is a self-report instrument, designed and tested with parents. The instrument assesses the availability of inside space, outside space, variety of stimulation, fine-motor toys and gross-motor toys. Questions are presented in a user-friendly manner with pictorial examples of the general classification to help parents identify available categories and specific types of items.

Although its promise as a research and intervention tool is exciting, we feel that its applied use is of equal significance. For example:

- The AHEMD-SR is an excellent best practices document for identifying developmentally (age-) appropriate toys and play materials, toys and play items that have a high likelihood of promoting optimal physical and motor development if parents make them available. The AHEMD-SR helps parents answer the questions "what should be in the home?" and "what should we be doing to help our child's development?"

- School readiness may be improved by providing appropriate educational and developmental toys. Of the various abilities important to child development, most experts agree that fine-motor and visual-motor skills are fundamental to success in daily activities, play, and later academic success. Deficits with such skills can affect a child's ability to eat, write legibly, use a computer, turn pages in a book, and perform personal care tasks such as dressing (tying shoes) and grooming.

- This instrument can be used as a tool for early intervention. That is, assessment of the home followed up with modification to meet the specific needs of your child. Areas for these specific needs may come from your child's school progress reports or a medical professional (physical therapists are currently using this instrument to assess the home and make recommendations for parents).

Since its published report of findings, the AHEMD-SR has been used in five countries and translated from English to Portuguese, Spanish, Chinese, and Italian. The AHEMD-SR is free and available for down load from this website: http://www.ese.ipvc.pt/~dmh/AHEMD/ahemd.htm. There is also an online version that includes a calculator (Microsoft Excel required) with an instant result section indicating the score 0-4 (very low to high) for each of the five categories.

Dr. Carl Gabbard is professor and Director of Motor Development Studies at Texas A&M University, and a fellow in The American Academy of Kinesiology and Physical Education. He has published over 200 articles of research and application related to motor development and physical activity for infants and children. He is the author of Lifelong Motor Development, *5th edition (2008) and has co-authored and reviewed several major curricular documents. Priscila Caçola (MS) is a doctoral student and research assistant studying with Dr. Gabbard. Dr. Luis Paulo Rodrigues is a professor at Polytechnic Institute of Viana do Castelo, Portugal, and a former student of the Texas A&M motor development doctoral program.*

Children in Hospitals

By John E. Monaco, MD

Accidental Overdose

Sabrina is an energetic seven year old. In fact, she is so energetic that she is on two medications to control her behavior. She, like so many kids today, has ADHD. She is on an amphetamine-like stimulant during the day to improve her concentration and make her less distractible, and at night she takes Clonidine to help her relax and sleep. When she doesn't take her daytime meds, she is completely uncontrollable – her father described her as "bouncing off the walls" when she is unmedicated.

This is why, when Sabrina's dad found her fast asleep and unarousable in the middle of the living room floor at 10:30 last Sunday morning, he knew something was terribly wrong. Thinking quickly, he ran immediately to where he kept the Clonidine, on top of the refrigerator, and noticed that three pills had been removed from the medicine "sleeve" they had received from their pharmacy. (Later he would tell me that he wished they had placed the medicines in a childproof bottle like they used to.) Still, he was flabbergasted that Sabrina would go through the trouble of climbing on top of the refrigerator to find the pills.

Clonidine is one of those strange drugs that was first used in adults to treat high blood pressure, but was then later found to have profound sedative qualities, particularly in children. When kids take too much, though, and that may mean only a pill or two more than their usual dose, not only do they become heavily sedated – almost comatose – but also they are at risk of life-threatening decreases in heart rate and blood pressure. Sabrina was placed in our pediatric ICU after admission for these reasons.

Upon her arrival to our unit from the ER, she was deeply medically dulled, and her heat rate and blood pressure were dangerously low. Discussion with our poison control center revealed that the peak effect of the medicine would be two to four hours after ingestion, but she could experience effects up to ten hours after ingesting the pills. The problem with kids taking medicines they shouldn't take is that, because of the very nature of the behavior, we rarely know exactly when the child ingested the pills. This makes extended observation and monitoring all the more important.

Sabrina was in a state of deep, deep sleep as a result of her overdose, and her heart rate drifted into the low 50s and occasionally high 40s. At her age, her heart rate should be twice that. Because she managed to stay well oxygenated and perfused, we did not directly intervene to raise her heart rate. If she had become symptomatic, she would have been given a medicine like Atropine, which blocks the chemical released by nerves to slow the heart rate. Her blood pressure was also quite low – at one point 70s/30s – which we treated by giving her generous IV fluids and placing her bed in the head-down position. If this had not worked, she might have required a continuous drip of a cardio tonic medicine that would raise her blood pressure. Luckily the more conservative measures were all that was required.

Almost like clockwork, within eight hours after her admission, Sabrina began to come around. She told us that she had taken the pills because she had missed her dose for a couple of days and thought she would "catch up." (I should tell you, that despite her hyperactivity, Sabrina is one of the brightest seven year olds I have run across in some time.) She had a ravenous appetite and ate two breakfasts, one of which would have satisfied a child twice her size. Her blood pressure and heart rate normalized nicely and it appeared that Sabrina had escaped any long-term effects of her overdose.

When I asked her if she had learned anything from her admission to the hospital, she paused for a moment, looking away from the cartoons that had been the only distraction to hold her attention for any length of time. She said, "You mean about taking too much of my medicine?"

"That's exactly what I mean!" I responded.

"Yes, I learned that I should take only what my daddy gives me." And then she turned immediately back to her cartoons. Clearly her dad had already begun to use the experiencing as a teaching moment.

Continued on page 9

"Baby Doc" Eden Explains

By Alvin N. Eden, MD

The Terrible Twos - Denaturing Discipline Part II

In my previous article I discussed some of the problems associated with "the terrible twos" and gave examples of some poor and inefficient discipline techniques many parents use when their toddler misbehaves. I would now like to share with you what I consider the correct methods to teach your young child right from wrong, and to stop his destructive tendencies and his temper tantrums. The goal is to encourage self-control and self-discipline.

Five Techniques

Distraction Although it may not work too well at the toddler age (it is more effective with older children) it is definitely worth a try. Whenever possible, try to distract or redirect your child to another activity. For example, turn on some music or ask her to sing a song along with you. There is an old saying "music has charms to soothe a savage beast." Sometimes it also soothes a savage toddler. Tickling her or making funny faces to change her mood sometimes does the trick.

Separation Another highly effective method of teaching or disciplining your youngster when she misbehaves is to simply take her away from the place of trouble. For example, if your child is playing in the park, having a great time and suddenly decides to bite her friend, immediately remove her from the park and take her home – such a technique will teach her that there are unpleasant consequences that follow unacceptable behavior. This leads me directly to the next technique, explanation.

Explanation Your young child deserves an explanation for your decision to remove her from the area or activity because of her unacceptable behavior, in this case, for biting her friend. By 18 months of age, most toddlers have good understanding. After getting her home, calmly explain to her that biting is wrong and can hurt her friend. To teach her not to ever do it again, explain that because she bit her friend she can't go back to the park that day. Establishing rules or regulations and not explaining why you have done so makes it very difficult for your child to understand what's going on and to adhere to the rules. So it is important to set the rules clearly and consistently.

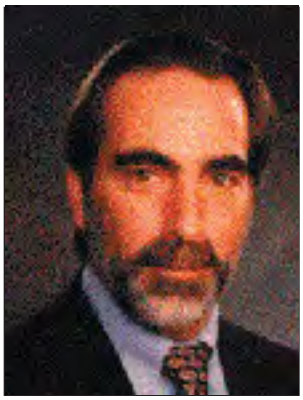
Compromise Many parents are surprised when I suggest that they try to compromise with their toddlers. I hear "But I know better." Maybe so, but compromising at times can work very well, and there is no downside. There is no question that you and your child will have many differences of opinion, but there are times and situations when it will be helpful to give in and let your child have her way. Let me explain what I mean. If the dispute is minor and the outcome not particularly important, for example like not finishing her meal, don't fight about it. Let her win some small battles and you will have a better chance of winning the big ones. An example of a big battle is biting. In that case, there is never a compromise.

Punishment Yes, there is a place for punishment in teaching your child right from wrong. It is important to always explain to your child the consequences of her behavior ahead of time. When punishment is used, try to teach a lesson whenever possible. Sending her to her room for not putting her toys away teaches her nothing. But rather, not allowing her to play with those toys for a while will help her understand the situation.

What about spanking? I believe this form of punishment should be reserved for special occasions. Some examples of what I consider special occasions would include a child who decides to turn on the gas jets on the stove, or one who runs out into the street traffic. The appropriate punishment for less important infractions is taking away certain privileges. If you punish her often for every minor misbehavior, any type of punishment, including spanking, will lose its effectiveness.

A final thought. Since West Point does not accept two or three year olds, I would advise you not to treat your child as though he were in military school. There will be times when you will have to put your foot down and take firm action. Save those occasions for when it really counts, and look the other way when his misbehavior is merely a little out of line.

Dr. Eden is the chairman of the department of pediatrics, Wyckoff Heights Medical Center, Brooklyn, New York and a clinical professor of pediatrics, Weill Cornell Medical Center, New York, NY. His latest book, Positive Parenting, *is now available.*



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Assessing Aggression

Is aggression a bad thing? Are boys more aggressive than girls? What causes kids to be aggressive? Before you answer these questions too quickly, it might be wise to take a closer look at the subject of aggression. It is considerably more complex than you might imagine.

First, it is important to make a distinction between "instrumental" aggression and "hostile" aggression. Instrumental aggression is aggression that is employed in the pursuit of a goal. Hostile aggression is aggression that is employed for no other purpose than to hurt someone.

Let's say a preschool class has just been released for outdoor play. The children all rush out the door because they all want to be the first to go down the playground slide. As he is rushing out the door, one child knocks over another child. That is instrumental aggression. He wasn't trying to hurt anyone, he was just doing what he had to do to get out of the door first. Now the kids are climbing up the ladder to go down the slide. One child turns around and kicks another child in the head. That is hostile aggression. There is no reason for him to do that except specifically to hurt the other child.

Which brings us back to the question of whether or not aggression is a bad thing. The fact is that in our society and culture, instrumental aggression is not only accepted, it is encouraged and applauded. Someone goes into business and is an extremely aggressive entrepreneur. As he becomes a success, he forces a couple of his competitors into bankruptcy. We do not condemn him for that. He wasn't out to hurt those people, he was simply determined to become a success. That others got hurt in the process, well, that's the way the cookie crumbles.

A football player carrying the ball is running down the field. A potential tackler approaches and he sticks his hand in the guy's face – a classic "stiff arm" move. Very aggressive. But we don't condemn him. We cheer him. He's not looking to hurt the guy, he's just trying to score a touchdown. Now if he gets into the end zone and then turns around and kicks the other guy in the shins, we boo him. We definitely do not like hostile aggression.

So, getting back to those preschoolers. The kid who knocks over another child as he is rushing out the door should be duly chastised to be careful and to watch where he is going. But you don't come down on him as harshly as you do the kid on the ladder who kicked another kid in the head for no reason other than to hurt him. Instrumental aggression can and should be considered acceptable as long as it is employed judiciously and with appropriate caution. Hostile aggression, on the other hand, should not be tolerated under any circumstances.

Okay. Let's address the issue of boys versus girls. I think most people would immediately reply that boys are more aggressive than girls. However, if you observe children carefully, you will notice that the amount of aggression employed by boys and girls is pretty much equal. Where you see a big difference is in the type of aggression they employ. Which brings us to the distinction between "overt" and "relational" aggression.

Because of the way we socialize our boys, they tend to favor overt aggression. That is out-in-the-open, direct, physical aggression. They punch, kick, shove, or at least threaten bodily harm. Because of the way we socialize our girls, they tend to favor relational aggression. That is relatively subtle, non-physical aggression. They ostracize from the group, spread rumors, and otherwise undermine someone's social standing. So, if a little boy is mad at you, he will knock you upside your head – overt aggression. Meanwhile, if a little girl is mad at you, she will tell everyone that you still wet the bed – relational aggression.

I've always said that sticks and stones may break my bones, but names really hurt. If a boy knocks you upside your head, it hurts. But after a couple of days, the bruise fades and the pain goes away. On the other hand, if a girl tells everyone you still wet the bed, you never get out from under that. Years later in high school they're still calling you "Beddy Wetty." And the thing is that while all the boys are getting into trouble because their overt aggression is impossible to miss, the girls are ripping each other to shreds in the back of the room and no one is doing anything about it because their relational aggression is flying under the supervisory radar.

Consequently, it is necessary to control the boys and teach them better ways to deal with their anger, frustration, and other ill feelings. But it is critical to keep an eye on the girls and do the same for them. Their favored form of aggression is no less damaging and no less appropriate simply because it does not involve fractures and blood.

Why are some kids more aggressive than others? That is the million-dollar question. And those who seek to answer it usually start with the classic "nature versus nurture" debate. I think it is reasonable to assume that some human beings are genetically more "predisposed" to aggression than others. However, I think it is unreasonable to use DNA as an excuse for inappropriate behavior.

Clearly, parents have the ability and responsibility to shape and control the aggressive tendencies of their offspring. And most parents dutifully admonish their children for inappropriately aggressive activities. Unfortunately, I also see a lot of mothers and fathers surreptitiously forgive and even reward their little one's inappropriate aggression as long as he is victorious. Telling your child that fighting is against the rules but giving him the impression that you're proud he came out on top is only going to reinforce and not regulate improper behavior.

What about the media? Many people claim that violent television programs, movies, and video games propagate inappropriate aggression. The kids on the playground are kicking each other in the head. The parents aren't rewarding them for such behavior, nor are the teachers. So what keeps it going? Well, one theory is that this is a case of "vicarious reinforcement." The kids watch their favorite action heroes kicking people in the head, and those action heroes get all the glory and other rewards. As a result, the kids are encouraged to do the same.

Personally, while I am willing to acknowledge that vicarious reinforcement is a real phenomenon, I do not believe it is powerful enough to overcome parental admonitions and recriminations. A lot of kids watch those television shows and movies and play those video games, yet only a tiny percentage become thugs. Furthermore, as Sigmund Freud himself would contend, those violent television shows, movies, and video games actually may serve as a healthy way for children to release their anger, frustration, and other ill feelings through fantasy. Given that media bashing seems to have become a national pastime, this "catharsis" theory is not particularly popular these days, but I do believe it has a fair amount of merit.

So the bottom line is that mothers and fathers must take their child's aggressive behavior seriously, but they cannot look at it superficially. If their child is to become a successful but responsible citizen of the world, it is imperative that parents treat this type of behavior with the thorough analysis and thoughtful response it deserves.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicntrinc@aol.com.

Overdose – continued from page 6

It is quite challenging in our drug-dependent society to give pills to kids all day long, and then try to get them to understand that the same pills that make them better can kill them if taken in the wrong dosages. This is a difficult paradox for kids to grasp because they are naturally curious, they often need to place all sorts of thing in their mouths, and they have budding autonomy. So we adult caregivers must be extremely diligent in protecting kids from themselves to prevent cases like Sabrina's from becoming tragedies.

John E. Monaco, MD, is board certified in both pediatrics and pediatric critical care. His latest book, Moondance to Eternity*, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.*

Hidden Sugar

Food	Serving Size	Tsps of Sugar
Chewing Gum	7 sticks	4
Chocolate Bar	2 oz	7
Chocolate Caked Iced	4 oz slice	10
Chocolate Milk	8 oz	7
Cola Drink	16 oz	12
Fruit & Yogurt	8 oz	8
Gelatin Dessert	1 cup	8
Glazed Donut	1	6
Ice Cream	1 cup	6
Jelly Beans	12 oz	12
Kool-Aid	8 oz	6
Orange Soda	12 oz	12
PB & J Sandwich	1	5-7
Pecan Pie	5 oz slice	12
Pork & Beans	1 cup	5
Sweetened Cereal	2 oz	7
Thick Shake	11 oz	9

Nutrition Council

Children's Emergencies

By Martin Belson, MD

Travel Safety

We have all been there: standing in a long line at the airport, sitting on an airplane with a young child, or maybe taking a long road trip in the car to a fun destination. Traveling with children can be exciting and fun for the whole family, yet a plane or car ride can be not only stressful for parents but also can pose potential hazards for our children. This article provides safety tips for domestic travel with children.

Planning for Your Car or Airplane Trip

Preparation is very important before taking your child on a trip. Planning ahead by bringing extra supplies, making organized lists, and looking up hospital or physician information ahead of time can save your family unnecessary stress in an unexpected situation.

Supplies Depending on your destination, consider these supplies to take along: first aid kit, your child's regular medications, water and snacks, alcohol-based hand sanitizer, child-safe hand wipes, baby formula, diaper rash ointment, diaper changing supplies, children's Benadryl or another antihistamine for allergic reactions, insect repellent, acetaminophen (Tylenol) rectal suppositories, acetaminophen (Tylenol) or ibuprofen (Motrin) for oral use, topical antibacterial antibiotics (Neosporine), sunscreen, a portable high chair (a compact, easy-to-pack high chair is invaluable on the road), a new bag of safe toys for the car or plane, and a combination stroller/car seat.

Medical History Consider creating a medical history form for your child in case you end up in an ER that includes the following information: child's and parent's name, address, and home phone number, blood type, immunizations, doctor's name, address, and office and emergency phone numbers, health insurance information, chronic and current health problems, current medications, and allergies to medications or food.

Medical Care In all the excitement of planning a trip, it is easy to forget about what you would do if your child needed medical attention. Plan ahead by checking to see if a children's hospital is near where you plan to visit. If not, is there a facility where pediatricians evaluate children in the ER? If not, know the location of the nearest ER. Also check to make sure the facility you may have take your child accepts your insurance. For more information to prepare for a trip to the ER and what to expect, go to http://www.kidemergencies.com/ERchecklist.pdf.

On the Road and in the Air

Car Travel

Trying to keep children safe and happy during a long car ride can seem impossible. Children can easily become restless or irritable when on a long road trip, so try to keep them occupied by pointing out interesting sights along the way and by bringing soft, lightweight toys and favorite CDs. With my kids, we play a game where you get points based on the type of animal or object that you see while driving (e.g., a cow is worth five points). We also play "I Spy" where they have to find something that I spot from the car while riding. Plan to stop driving and give yourself and your child a break about every two hours.

It can never be said enough: never, not for a moment, leave your child alone in a car. Temperatures inside the car can reach deadly levels in minutes, and your child can die of heat stroke.

Air Travel

If trying to keep children safe and happy during a long car ride is tough, that task can become much more complicated and difficult during a long plane ride, when you can't stop the plane and get out! As with a long car ride, planning for a plane ride can reduce the stress of unexpected events should they arise.

Planning Take all essential items for the children in carry-on luggage (food, diapers, medicine, and other items to last through possible flight delays and lost luggage). Bring along safe toys: don't bring toys that are sharp, heavy, or that break easily. Consult your pediatrician before flying with a newborn or infant who has chronic heart or lung problems, exhibits upper or lower respiratory symptoms or has had an episode of an ear infection or ear surgery with in the previous two weeks. Sedative medications may cause over sedation or sometimes agitation. Benadryl can be useful for some

children but, similar to any medication for sedation, should be administered as a test dose before travel to determine the effect on the individual child.

In the Airport Stressed about security lines at the airport? You're not alone. Here is a summary of tips form the Transportation Security Administration (TSA) to make the screening process with your child a little less stressful:

The Screening Process Allow yourself and your family extra time to get through security. Talk to your children before coming to the airport about the security screening process. Let them know that their bags (backpack, dolls, etc.) will be put in the X-ray machine and will come out the other end and be returned to them. Discuss the fact that it's against the law to make threats (e.g. "I have a bomb in my bag"). Threats made jokingly (even by a child) can result in the entire family being delayed and could result in fines. All child-related equipment that will fit through the X-ray machine must go through the X-ray machine. When you arrive at the checkpoint, collapse or fold your child-related equipment. Secure items that are in the pockets, baskets, or are attached to the equipment and place them on the X-ray belt for inspection.

The Metal Detector If your child can walk without your assistance, then we recommend that you and your child walk through the metal detector separately. If you are carrying your child through the metal detector and the alarm sounds, our security officer will have to additionally screen both you and your child. Remove babies and children from their strollers or infant carriers so that our security officers can screen them individually. You may not pass the child to another person behind you or in front of you during this process.

Traveling with Liquid: Medications, baby formula and food, breast milk, and juice are allowed in reasonable quantities that exceed three ounces and are not required to be in a zip-top bag. All items, including formula, breast milk, and juice, will be inspected. However, you or your infant or toddler will not be asked to test or taste breast milk, formula, or juice. Security officers may test liquid exemptions (exempt items more than three ounces) for explosives. All liquids, gels and aerosols must be in three-ounce or smaller containers. Larger containers that are half-full or toothpaste tubes rolled up are not allowed. Each container must be three ounces or smaller.

During Plane Travel Injuries and deaths can occur in children held on adult laps during turbulence and nonfatal crashes. The AAP recommends that children should be placed in a rear-facing Federal Aviation Authority (FAA)-approved child-safety seat until they are at least one year old and weigh at least 20 pounds, that children older than one year of age and 20-40 pounds in body weight should use a forward-facing FAA-approved child safety seat, while children weighing more than 40 pounds can be secured in the aircraft seat belt.

Based on analyses of dozens of aviation incidents and accidents involving children, www.airsafe.com provides the following tips that can make the trip safer for children: Use a child-safety seat as described above, seat your child away from an aisle (small children enjoy reaching out and exploring, but if they are on the aisle they could get hurt if their arms get bumped by a person or serving cart passing down the aisle), supervise your child at all times, and keep your child belted or in a child restraint system at all times as turbulence can happen at anytime. If emergency oxygen masks deploy, put your mask on first so that you will be of sound mind to help your child. If your child has a medical condition that may become an issue during the flight, make a flight attendant, counter agent, or gate agent aware of that possibility before the flight.

Another tip from the AAP: In order to decrease ear pain during descent, encourage your infant to nurse or suck on a bottle. Older children can try chewing gum, filling up a glass of water and blowing bubbles through a straw (four years of age or older), or blowing up balloons (eight years of age or older).

Martin Belson, MD is a pediatric emergency medicine physician at Children's Healthcare of Atlanta at Scottish Rite, a medical toxicologist, creator/editor of www.kidemergencies.com and host of the Pediatric Health Hour *every Wednesday at 9AM on www.radiosandysprings.com. His website is one of five that received the iParenting Media Award for the Greatest Products of 2007.*

Sugar Linked to Asthma

Kids that eat a lot of sugary food may be doing more than just increasing the size of their waistline. There's evidence that the increase in sugar consumption may be a factor in the increase in the amount of asthma in children. Nine percent of children suffer from asthma. That's twice as many as did in the 1980s.

According to Sonja Kierstein, PhD, of the Nestle Research Center in Lausanne, Switzerland, one hypothesis is that a diet with a lot of sugar may "prime" the immune system of the airways, making it more susceptible to reacting to allergens. This causes narrowing of the airways and excessive mucus production, which, in turn, causes wheezing and shortness of breath.

Journal of the American Medical Association, 6/07

Pediatric Points

By Carolyn Roy-Bornstein, MD

The Choking Game

I was working in the emergency room last week when a nine-year-old boy came in with difficulty breathing. While the nurses got his vital signs, I asked his mother the usual questions in a pediatric history. When did it start? Has this ever happened before? Any fever? I recorded her answers. He had asthma as a kid but hadn't been sick in several years. He was fine when he went to school this morning. Besides the trouble breathing, there were no other problems.

On physical exam, outside of the wheezes in his lungs, I at first didn't notice anything unusual. Then on closer inspection I saw a tiny line of broken blood vessels on the front of his neck, a rosy red string, like a bruise. I asked the boy and his mother: Any fighting? Any necklaces getting caught on things? No and no. Then I asked the boy, both in front of his mother and later, with her out of the room, Have you been playing the choking game?

Five or maybe even ten years ago, I wouldn't have even known to ask that question. And maybe as a parent, neither would you. But now we all need to know to ask the question. We all need to know: What is the choking game?

The choking game consists of strangulation, either self-strangulation or strangulation by another person, for the purpose of achieving a brief state of euphoria, a "high." This state is brought about by a temporary lack of oxygen to the brain. Individuals who participate in this potentially deadly game are typically under 20 years of age and may be as young as nine. The "game" is known by many other names, including suffocation roulette, space monkey, airplaning, California high, cloud nine, funky chicken, choke out and others. Hands may be used to perpetrate the strangulation but other ligatures, such as belts, T-shirts, scarves, shoelaces and bed linens can also be used. When the strangulation is prolonged, severe or permanent neurological injury – including short-term memory loss, seizures, hemorrhages in the eyes and stroke – or death can occur. The "game" is dangerous enough when there is more than one participant. When children experiment alone, the consequences can be tragic.

The problem with getting a handle on how frequently death from the choking game occurs is that there are no public health agencies currently collecting data on the phenomenon. Death certificates that simply describe the death as strangulation may not be able to distinguish death due to the choking game from death by suicide.

In a recent (Feb. '08) report, the CDC (Centers for Disease Control and Prevention) attempted to estimate the number of deaths from the choking game that occurred among youth from 1995 to 2007. Due to the above limitations, they relied on Internet searches of news media reports, as well as on reports on two choking game awareness web sites. The CDC concluded that 82 deaths in 31 states were likely a result of the choking game; more than eighty-six percent of the deaths occurred in boys. The mean age of the children who died was 13.3 years. Importantly, most of the deaths occurred while the child was alone. Also, none of the parents of any of these children was aware of the choking game until after the death of their child.

So just how prevalent is the practice? Again, it's hard to say. Every two years high schools and middle schools across the nation administer the Youth Risk Behavior Surveillance System survey. It's a questionnaire developed by the CDC to monitor high-risk behaviors in students. It includes questions about drugs, alcohol and sexual activity. In 2006 a county in Ohio included its own question about the choking game in the survey. They found that 11% of the children aged 12 to 18 years, and 19% of the kids 17 to 18, reported playing the "game" at least once.

We should all be able to recognize the warning signs that may indicate experimentation with the choking game, including bloodshot eyes, pinpoint bruising around the eyes or face, marks on the neck and frequent or severe headaches. Suspicious paraphernalia such as ropes, scarves or belts tied to furniture or found knotted on the floor should alert parents to the possibility of involvement. A sudden or unusual need for privacy such as locked bedroom doors as well as

Contained on page 14

Pediatric Insider

By Roy Benaroch, MD

Sunburn

Q What's the best way to protect my childen from sunburn?

A Summer is a time for swimming, sunshine, and fun – but too much sunshine can be a problem. Overexposure to sun not only causes painful sunburns, but also prematurely aged and wrinkled skin. Sun damage also contributes to skin cancer. Families should keep in mind that a child's skin is more sensitive to the harmful effects of sun exposure than an adult's.

To avoid skin damage from sun exposure, avoid direct sunlight in the middle of the day, from 10:00 to 3:00. Wear broad-rimmed hats and sunglasses, and wear light-colored clothing to reflect the sun's rays. Clothing that stays dry and is rated for sun protection works best at preventing sun damage.

Sunscreen can be used safely at any age. Look for a product that provides protection from both UVA and UVB sunlight, and is rated at SPF 30 or more. Sunscreen should be applied liberally – an adult application should use one full ounce. A typical bottle of sunscreen should only have enough for about eight applications – so if your bottle is lasting longer than this, you're not applying enough! Sunscreen should be reapplied frequently, especially if you've gotten wet.

When outside, don't forget to drink plenty of water. Small children may not be able to ask for water when they're thirsty, so parents have to offer them frequent sips while in the sun.

If you or your child does get sunburned, get out of the sun right away to prevent further damage. Take ibuprofen (for children older than six months) for pain, and provide extra fluids to prevent dehydration. Soothing gels that contain benzocaine, often also with aloe, can help. Topical agents like these feel even better if they're kept in the refrigerator. Sunburned skin should be gently washed daily with lukewarm soapy water.

Though children with pale skin, light-colored eyes, and freckles are the most sensitive to the sun, even kids with dark skin can develop sunburns and sun damage. Parents should set a good example by taking good care of their own skin, and teaching their children to avoid the dangers of sun overexposure.

Monitoring Email

Q I have a daughter in middle school. She's a good kid, sometimes a little anxious, but I don't think she's doing anything bad. Is it OK if I read her emails and IMs?

A In general, I think it's best if you respect her privacy and don't go snooping into these things. You may really harm your relationship with her if you go through her things, and you need her to remain trustful of you as she goes through adolescence.

That being said, there may be a time where some snooping is necessary. If you have genuine concerns that your child is doing something unsafe, you'll have to act. For instance, a mom once told me about her suspicions that her daughter was developing an unhealthy Internet relationship. Mom had noticed how furtive her child had become while using the computer. She confronted her daughter directly, and after a few weeks it became clear that she had been planning to meet her Internet paramour in person – a very dangerous idea. Once mom got more involved, she was able to help her daughter disengage from the chat rooms and find other interests.

With this kind of technology, you need to keep a general eye on things. I suggest that computers with Internet access never be in children's bedrooms, but rather in common areas of the house where parents can keep an eye on what's going on. Children should be taught from an early age what information shouldn't be shared with Internet friends. Though there may be times when you have to pry, building a relationship of trust will make it more likely that your children will come to you when there's a problem. That's the most important lesson of all.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

More Questions - page 14

Time for Solids

Q Sometimes my seven-month-old daughter seems to love her solids, but other times she prefers her bottle. How important are solid foods at this age? How can I get her to realize that the solids are the "food" rather than the bottle? Also, can I puree what I'm eating instead of buying baby foods?

A At seven months of age, babies are still getting almost all of their nutrition from either a bottle or nursing. Solids at this age are important, but not because they're a significant source of food energy or nutrition. They're important because this is a transitional age, when babies are starting to change from being "drinkers" to "eaters." It's a gradual process, and some babies take to it more quickly than others. Don't be discouraged if some days your daughter is more interested in the bottle than others, or if some days she can't seem to get enough of her solid foods. Either way, she'll get plenty to eat and grow.

The best way to encourage a healthy change from drinking to eating is to set a good example. Eat as a family, as often as you can, so she sees how other people eat. By the time she is nine months old, give her a chance to start feeding herself with soft items like cubed, cooked vegetables. She'll soon have the dexterity to feed herself almost any soft foods from your plate. By about 12 months of age, many babies will refuse to be fed baby food, and will insist on feeding themselves "table foods." Even at 12 months, many babies are still eating baby foods, and some still even want their bottle. Let your daughter work through this at her own pace. Offer appropriate foods in an appropriate way, and then let the baby decide whether or not she wants to eat it.

You can make your own baby foods rather than buy the commercial jar foods. A quick Google search turned up several dozen sites with explicit instructions and recipes. Follow directions carefully, especially concerning food handling and storage.

Dr. Roy Benaroch is a general pediatrician in practice near Atlanta, Georgia, and an assistant clinical professor of pediatrics at Emory University. He's a frequent contributor to Pediatrics for Parents, addressing both health and behavioral issues in our monthly Q&A column. Dr. Benaroch has written two books for parents, and has his own blog at http://www.pediatricinsider.com/.

Need a Gift?
Think Pediatrics for Parents

Choking Game - continued from page 12

disorientation after spending time alone are also red flags.

As with any risky behavior, open conversation with kids is the key to shared information in both directions. Dinner table discussions can help children share concerns they may have about themselves or their friends while affording parents the opportunity to teach kids about its dangers.

The point is that educating ourselves and our children about the dangers of the choking game is the first step toward reducing its morbidity and mortality. As for the boy in the ER, he turned out to have a simple asthma attack, brought on by hanging out in his sister's room with her cat and her cigarette smoke. With some nebulizer treatments and a course of Prednisone he did just fine. He denied any knowledge of or participation in the choking game, but now at least he and his mom both know about this potentially deadly "game."

Carolyn Roy-Bornstein is a board-certified pediatrician in private practice in Haverhill, MA.

Vitamin D Deficiency

Vitamin D deficiency in children increases their risk of serious health problems later in life, including decreased bone density and type 1 (insulin dependent) diabetes, which is why all pregnant and breastfeeding women should take a prenatal vitamin containing vitamin D. This is the recommendation of Dr. Tohru Yorifuji of Kyoto University Hospital. His research on 1,120 newborns found that 22% had, at age five to seven days, craniotabes (softening of the skull bones). He attributed this condition to a vitamin D deficiency. Yorifuji also found that breastfeeding without a vitamin D supplement prolonged the problem.

The study found an interesting seasonal influence on vitamin D levels. Since the body produces vitamin D when the skin is exposed to sunlight, women who are pregnant during the winter get less sun exposure and are more likely to have insufficient vitamin D levels.

According to Dr. Yorifuji, "Until more research is done on the effects of perinatal vitamin D deficiency, we suggest treating breastfed infants with craniotabes with vitamin D, or preferably, treating all pregnant women with vitamin D."

Journal of Clinical Endocrinology & Metabolism, 04/08

Food Poisoning

By Andrea Lutz

When your child is ill, you can be frightened and confused. How do you know what's wrong and if it's time to call a doctor? And if your child is vomiting, how do you know if she's seriously ill or just has an upset stomach or food poisoning?

Various psychosomatic problems can cause vomiting, especially stress. A bump on the head after a fall occasionally induces a single instance of vomiting, as can car rides and other repetitive motion. Vomiting accompanied by constipation, cramps, odor and a distended abdomen may indicate an intestinal blockage that requires immediate medical attention. Vomiting may indicate serious medical conditions, but, fortunately, most instances run their course within a few days and pass without complications. Most bouts of vomiting are a result of either gastroenteritis or food-borne illness.

Although it is commonly called the "flu," gastroenteritis is not caused by the influenza virus (which causes respiratory symptoms) and is not prevented by those vaccines. Several different viruses – and some parasites or bacteria – damage the lining of the intestines when ingested, inducing vomiting, watery diarrhea, and symptoms of a cold within a day or two. Chills, headache, fever, and stomachache last one to ten days (depending on the virus) and rarely require medical attention. If your child has a very high fever, symptoms of a bacterial infection (such as sore throat, earache, mental confusion, severe headache, or painful urination), signs of dehydration, or is unable to keep down water within 12 hours, call your child's physician.

Ingesting viruses, parasites, bacteria or other toxins can cause food-borne illness, or "food poisoning." Because food poisoning is more of a description than a diagnosis, and because it has varying sources, incubation periods, symptoms, duration and complications are also varied.

Commonly, symptoms of food poisoning resemble gastroenteritis (vomiting, watery diarrhea sometimes colored with blood, abdominal pain), but rarely include fever. It can take up to four days for a person to become ill (it is uncommon for a person to become sick immediately after ingestion), and the symptoms remain as long as there are toxins in the body, depending on the type that were consumed, the amount, and an individual's resistance to them.

It may be impossible at home to distinguish gastroenteritis from food poisoning, and both illnesses usually clear up without a doctor's care. But some types of food poisoning, such as E. coli or botulism, have different and more severe symptoms, and any type of illness with prolonged vomiting and diarrhea may cause dehydration. In rare cases, food poisoning can lead to complications, including shock and even death.

Since food poisoning causes 5,000 deaths a year in the United States alone, and children under age five are among the group at greatest risk, seek emergency medical care if you note signs of any of the following symptoms:

- Botulism poisoning: Muscle weakness, including weak sucking and inability to hold up the head in infants, difficulty breathing, swallowing, speaking or opening the eyes, blurry vision, and increased heart rate
- Hemolytic uremic syndrome (HUS): fever, extreme fatigue, pale skin, irritability
- Dehydration: sticky mouth or tongue, decreased or darkened urine, decreased tears, dizziness, weakness and muscle cramps, sunken eyes or fontanels ("soft spots") in infants, low blood pressure, increased heart rate, breathing and pulse, dry, flushed skin that has lost normal elasticity
- Shock: clammy, pale skin, chills, chest pain, weak pulse, shallow breathing
- Other symptoms may indicate different but severe complications: blood or green bile in stool or vomit, severe abdominal cramping or swelling, confusion, forceful vomiting in children under two months old.

Botulism poisoning, caused by the spore-forming bacterium Clostridium botulinum, is rare. This illness attacks the muscles and nervous system, with symptoms typically appearing 12-36 hours after ingestion. To help prevent botulism poisoning, never eat food from cans or jars that are swollen, spray when opened, or have broken seals. And, never feed infants honey.

Hemolytic uremic syndrome (HUS) is caused by the Escherichia coli O157:H7 (E. coli) bacterium. Extremely

Continued on page 16

Poisoning – continued from page 15

rare, HUS primarily affects children ages one through ten and can produce kidney failure, diabetes, and death when the body becomes unable to remove waste from the blood. To prevent some of the most common sources of E. coli consumption, cook all ground beef thoroughly (no pink) and drink only pasteurized apple juice.

Food poisoning is rarely caused by unsafe food sources (only 3% of cases). The remaining cases are a result of poor hygiene and improper handling, cooking and/or storage of food. It is often impossible to tell if food is contaminated since most bacteria do not produce an offensive odor, color, or texture. To help prevent food poisoning, keep all meat, seafood and poultry refrigerated – separate from foods eaten raw – until ready to cook. Prepare meats last (sinks, counters, utensils, cutting boards, etc., can become contaminated if meat is handled first, transferring bacteria to hands and other foods) and always cook meats thoroughly. Both gastroenteritis and food poisoning are best prevented through hand washing.

Alexandra Lutz researches parenting issues in the fields of health, psychology and education. She is a teacher and freelance writer in Rio Rancho, NM.

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